CCS ADMINISTRATIVE EXPENDITURE INVOICE

COUNTY: _____ **QUARTER:** _____

	CATEGORY/LINE ITEM	TOTAL EXPENDITURES	NON-MED-CAL			MEDI-CAL		
			TOTAL NON MEDI-CAL	STRAIGHT CCS 50/50 State/County	HEALTHY FAMILIES 65/17.5/17.5 Fed/State/Co	TOTAL MEDI-CAL	ENHANCED 25/75 State/Federal	NON-ENHANCED 50/50 State/Federal
A	*B*	*C=D+G*	*D=E+F*	*E*	*F*	*G=H+I*	*H*	*I*
I.	Total Personnel Expenses							
II.	Total Operating Expenses*							
III.	Total Capital Expenses							
IV.	Total Indirect Expenses							
V.	Total Other Expenses							
	TOTAL EXPENDITURES							

SOURCE OF FUNDS *Encryption Software = $ _____ (Vendor Invoice(s) must be attached)

I	*J*	*K=L+O*	*L*	*M*	*N*	*O=P+Q*	*P*	*Q*
MEDI-CAL								
	State Funds							
	Federal Funds (Title XIX)							
HEALTHY FAMILIES								
	State Funds							
	County Funds							
	Federal Funds (Title XXI)							
STRAIGHT CCS								
	State Funds							
	County Funds							
TOTAL SOURCE OF FUNDS								

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection, with the program; that I have not violated any of the provisions of Section 1030 to 1036 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claims; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

Signature of Authorized Official

Type or Print Name of Authorized Official

Date

Type or Print Name of Contact Person

( )

Telephone Number